Nutrition Database

DPD Nutrition Consultants, Inc.

Debbie Pepper-Dougherty, RD, LD

Name: _____ D.O.B. _____ Age: _____ Gender: _____

If minor: Parents/guardian names: _____

Mailing Address: _____ City / State / Zip: _____ Last 4 digits of SSN: _____

Preferred Phone #: ☐ H ☐ C ☐ W _____ Alt Phone #: ☐ H ☐ C ☐ W _____

Email: _____ Preferred contact method: ☐ Email ☐ Phone ☐ Text

Primary Care Physician: _____ Phone: _____

Who Referred You? _____ Phone: _____

Reason(s) for Referral / Personal Health Goal(s): _____

INSURANCE INFORMATION: Your health insurance plan is a contract between you, your employer, and/or insurance company. Insurance policies vary greatly in their coverage of medical nutrition therapy. It is the subscriber's responsibility to know what coverage they have under their health insurance plan.

NO SHOW & CANCELLATION POLICY: While we are committed to providing you with the best possible care, we understand that an appointment occasionally needs to be canceled. In order to achieve our goals in helping you, we need your assistance and understanding of our cancellation policy. We require a phone call at least 24 hours in advance of your appointment to cancel. No Shows and late cancellations will be directly billed to the patient for the time reserved. Please communicate with us to discuss emergency situations and severe weather conditions.

I ASSIGN PAYMENT directly to Debbie Pepper-Dougherty, DPD Nutrition Consultants, Inc. benefits assigned to me for the services rendered. I understand I am financially liable for any balance, such as co-payments, deductibles, policy exclusions, cancellation/no show fees and denied claims for referrals not being correctly done by the primary care physician. Fees not covered by insurance will be directly billed to the client, with payment due within 30 days.

I AUTHORIZE RELEASE of any personal health information (PHI) needed for medical nutrition therapy sessions and for processing of insurance claims to employees of DPD Nutrition Consultants, Inc., and any 3rd party billing service.

SIGNED: _____ Date: _____

Primary Insurance Co.: _____ Policy Holder's Name: _____ DOB: _____

Employer: _____

Address & Phone Number (If different than patient's): _____

Secondary Insurance Co.: _____ Policy Holder's Name: _____ DOB: _____

Employer: _____

15 Sky View Drive, Cumberland Foreside, ME 04110
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www.dpepperd.com

PATIENT HISTORY

Medical History:

Family History: _____

Food Allergies/Intolerance's: _____

Medications: _____

Vitamins/Supplements/Herbs: _____

Caffeine Use: _____ Smoking: _____ Alcohol Habits: _____

Bowel Habits - Regular: _____ Constipation: _____ Diarrhea: _____

Height: _____

Weight History - Heaviest: _____ Lightest: _____ Usual: _____

Previous diet(s): _____

LABS: Date: _____

Glucose/A1C: _____

Chol/TG: _____

HDL/LDL: _____

LIFESTYLE DATA

Occupation: _____ Employment: _____

Work Schedule: _____ Activity Level: ☐ Sedentary ☐ Moderate ☐ Active

Exercise Routine: _____

in Household: _____ Food Shopping: _____ Food Prep: _____

Meals eaten out: _____ Restaurants: _____

TYPICAL / 24 HR RECALL

Breakfast	Lunch	Dinner
Snack	**Snack**	**Snack**